Last Name	First (& Nicknames)	Address (Street)	(Apt.#)	Home Phone

City	State	Zip	Age/D.O.B.	Race	Ethnicity	Sex	Marital Status
				W B A/PI AI/AN O/U	H Non-His.	M F	S M W D SP U

Height	Size/Build	Hair	Complexion	Pregnancy Status	Place of Employment/Hours/Phone
				Y ___ wks N U	

Exposure		
First	Freq.	Last

Original Patient ID. Number

Other Identifying, Locating, or Medical Information

REFERRAL BASIS:	Disease 1	Disease 2	Initiating Agency
☐ Partner ___			
☐ Cluster ___			Invest. Agency
☐ Positive Lab Test			
☐ OOJ/ICCR ___			Clinic Code

Examination Date	Test	Result	Provider

Treatment Date	Drug	Dosage	Provider

FR Number	OOJ No.	OOJ Area	Due Date

Disease 1

Interviewer Number: | Disposition:

Date Initiated: | New Case #: | Dispo. Date:

Type Interview: | Diagnosis:

Type Referral: | Post-test Counseled? ☐ Yes ☐ No | Worker Number:

Disease 2

Interviewer Number: | Disposition:

Date Initiated: | New Case #: | Dispo. Date:

Type Interview: | Diagnosis:

Type Referral: | Post-test Counseled? ☐ Yes ☐ No | Worker Number:

Field Record

CDC 73.2936S (8/91)

Work Copy

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control

Note: See the reverse side of page one of this record for the codes and the reverse side of pages two and three for an abbreviated set of instructions. See the full set of Field Record instructions for further definition.